**CLINICIAN PROFILE**

Name of Organization or Practice: _____ Clinician Name: _____

Address in which services will be provided:

_____

Street Suite City State Zip

Clinician licensure: _____ License number: _____ Date issued: _____

Issuing body: _____ Expiration: _____ State of licensure: _____

Have you ever had disciplinary action against your license? Yes ☐
If Yes, please describe:

Please describe your experience in working with survivors of child sexual abuse:

Please describe any certifications or trainings that you have received that qualify you to work with survivors of child sexual abuse and dates received:

Please described modalities or approaches you use in working with survivors of child sexual abuse:

Completed by: _____ Title: _____ Date: _____